

ATTACHMENT 3

Sample CMS 1500 claim form for free-standing ambulatory surgery center services

PICA HEALTH INSURANCE CLAIM FORM PICA																																																																																																																																																																																										
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890																																																																																																																																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																					
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																																																																																																					
CITY Anytown			STATE WI		7. INSURED'S ADDRESS (No., Street)			CITY																																																																																																																																																																																		
ZIP CODE 55555			TELEPHONE (Include Area Code) (XXX) XXX-XXXX		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P																																																																																																																																																																																		
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																																																					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																																																																																																										
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																																																																																																																																																					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																																																																																																																																																																																					
19. RESERVED FOR LOCAL USE																																																																																																																																																																																										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 218.9 3. _____ 4. _____																																																																																																																																																																																										
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">A DATE(S) OF SERVICE To</th> <th colspan="2">B Place of Service</th> <th colspan="2">C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">E DIAGNOSIS CODE</th> <th colspan="2">F \$ CHARGES</th> <th colspan="2">G DAYS OR UNITS</th> <th colspan="2">H EPST/ Family Plan</th> <th colspan="2">I EMG</th> <th colspan="2">J COB</th> <th colspan="2">K RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th> <th>MM</th><th>DD</th> <th>YY</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>11</td><td>04</td><td>03</td> <td></td><td>24</td> <td></td> <td></td> <td>49321</td> <td></td> <td>1</td> <td></td> <td>XXXX</td> <td>XX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>										A DATE(S) OF SERVICE To			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPST/ Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE		MM	DD	YY	MM	DD	YY																	11	04	03		24			49321		1		XXXX	XX	1.0									2																						3																						4																						5																						6																					
A DATE(S) OF SERVICE To			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPST/ Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE																																																																																																																																																																					
MM	DD	YY	MM	DD	YY																																																																																																																																																																																					
11	04	03		24			49321		1		XXXX	XX	1.0																																																																																																																																																																													
2																																																																																																																																																																																										
3																																																																																																																																																																																										
4																																																																																																																																																																																										
5																																																																																																																																																																																										
6																																																																																																																																																																																										
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 1234JED					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																
28. TOTAL CHARGE \$ XXXX XX					29. AMOUNT PAID \$ XXX XX					30. BALANCE DUE \$ XXXX XX																																																																																																																																																																																
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>J.M. Authorized</i> MM/DD/YY					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 PIN# _____ GRP# _____																																																																																																																																																																																

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)